In the Supreme Court of the United States

OCTOBER TERM, 1978

NO. 78-563

THE AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.,
Petitioner

V.

JOSEPH A. CALIFANO, JR., Secretary OF U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Respondent

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE FIFTH CIRCUIT

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CITATIONS

CITATIONS (Continued)

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OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.,
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Petitioner respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit entered in the above entitled case on July 7, 1978.

CITATION TO OPINIONS BELOW

The opinion of the District Court for the Eastern District of Louisiana, printed in Appendix hereto, infra, page A-1, is reported in 421 F. Supp. 848. The opinion of the Circuit Court of Appeals for the Fifth Circuit, printed in Appendix A hereto, infra, page A-19 , is reported at 575 F.2d 1367.

JURISDICTION

The judgment of the Circuit Court of Appeals was entered on July 7, 1978, Appendix A, page A-19 , infra. No rehearing was sought. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

QUESTIONS PRESENTED

1. 42 U.S.C. § 1395ii incorporates into the Medicare Act 42 U.S.C. § 405(h), which precludes judicial review of certain administrative decisions under Title II of the Social Security Act. That section reads:

> "The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter."

The first question presented is whether 42 U.S.C. § 1395ii, incorporating into the Medicare Act 42 U.S.C. § 405(h), quoted above, precludes subject matter jurisdiction for the particular relief sought by the particular plaintiff, described with particularity in the "STATEMENT" below, under the Administrative Procedure Act, 5 U.S.C. § 551, 553, 701-706 and/or under the provisions of the United States Code governing federal question jurisdiction, 28 U.S.C. § 1331.

2. If so, whether such construction of Section 405(h), quoted above, precluding subject matter jurisdiction for the particular relief sought by the particular plaintiff in this matter, violates the due process clause of the Fifth Amendment to the United States Constitution.

3. If the provisions of Section 405(h) quoted above do not preclude subject matter jurisdiction or, in the event that they do and are ruled unconstitutional by the Supreme Court, then, in the interest of expediency and due to the unusual importance of the ultimate outcome of this action to physicians and their patients nationwide, whether the Supreme Court can proceed to a consideration of petitioner's entire claim on the merits and return a decision on the merits rather than remand.

STATUTES INVOLVED

The statutory provisions primarily involved in this petition for a writ of certiorari are Fifth Amendment, United States Constitution; 28 U.S.C. §1331; Section 10 of the Administrative Procedure Act, 5 U.S.C. § § 551, 553, 701-706; Social Security Act § 205(g,h), 42 U.S.C. §405(g,h); Social Security Act §1869(c), 42 U.S.C. § 1395ff(c); Social Security Act § 1872, 42 U.S.C. §1395ii; Social Security Act § 1878(f), 42 U.S.C. §1395oo(f); Social Security Act §1861(k), 42 U.S.C. § 1395x(k). These are printed in Appendix B, pp.B32-50 .

STATEMENT

Title XVIII of the Social Security Act establishes a federal program to provide medical assistance to certain individuals. Commonly referred to as Medicare, this program undertakes

to reimburse participating hospitals, physicians, and patients, under the terms of its various provisions, for medical care received and services rendered. Part A of the Medicare program provides hospital insurance for the aged and certain disabled individuals of any age.[1] The government undertakes to reimburse authorized "providers of services" for a covered beneficiary's health costs. These "providers" include hospitals, but do not include individual physicians. 42 U.S.C. § 1395x(u).

As a condition of participation in the Medicare program, the Act requires that each hospital must have in effect a "utilization review plan" to qualify as a provider. 42 U.S.C. § 1395x(e)(6),(j) (8).

With respect to composition of the reviewing group, i.e., the utilization review committee, Section 1861(k) of the Social Security Act, 42 U.S.C. § 1395x(k), provides that:

> "(k) A utilization review plan of a hospital... shall be considered sufficient... if it provides (2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been such a group which serves such institution, which is established in such other

1. Part B of the Medicare Program, not at issue in this matter, provides reimbursement for physician's services.

> manner as may be approved by the secretary.... The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution... or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of the subsection...."

Implementing regulations of the Secretary of HEW, codified at 20 CFR 405.1053(e) set forth three options for utilization review committee composition:

> "(e)(1) Standard; conduct of function by committees. The utilization review function is conducted by one or a combination of the following:
>
> (i) By a staff committee or committees of the hospital, each of which is composed of two or more physicians, with or without the inclusion of other professional personnel; or
>
> (ii) By a committee(s) or group(s) outside the hospital composed as in subdivision (i) of this subparagraph which is established by the local medical society and some or all of the hospital and extended care facilities in the locality; or
>
> (iii) Where a committee(s) or group(s) as described in subdivision (i) or (ii) of this subparagraph has not been established to carry out all the utilization

review functions prescribed by title XVIII, by a committee(s) or group(s) composed as in subdivision (i) of this subparagraph, and sponsored and organized in such manner as approved by the Secretary of Health, Education and Welfare."

Under 42 U.S.C. § 1395aa(a), the Secretary of HEW is given the power to authorize state agencies to determine whether a hospital qualifies as a "provider". In order to guide state agencies in their determination of whether or not a given hospital qualifies as a provider, HEW's Bureau of Health Insurance produced the "State Operations Manual," known as Health Insurance Manual 7, referred to herein as HIM-7. Unlike the statute, and unlike the Secretary's own implementing regulations, both quoted above, various paragraphs of HIM-7 create an order of preference in the availability of the three options for utilization review committee composition, effectually denying hospitals the right to the equal availability of the three committee composition options. [2]

Paragraph 2510 of HIM-7 provides in pertinent part as follows:

"The regulations, quoting the law, set forth the *preferable* committees as: one composed of medical staff members from the facility itself, or as an

2. Plaintiff physicians are not employees of hospitals, but as members of the medical staffs of said hospitals they are independent contractors with the hospitals and are directly affected by the utilization review committee composition preferences set up by the Secretary of HEW. For if the particular hospital with which any one or more of plaintiff physicians is affiliated as a medical staff member is not qualified by the Secretary as a "provider" then the hospital may not be reimbursed for the cost of hospital services provided to patients of plaintiff physicians.

alternate, one composed under the auspices of a local medical society which may also include representatives from local facilities (such as a community committee). *The third alternative, in the event either of the first two committees is not possible, is one composed of at least two physicians and approved by the Secretary of Health, Education and Welfare.*" (Emphasis ours).

Paragraph 2510(a) of HIM-7 provides in pertinent part as follows:

"(a) *In-House Committees*--Typically and preferably, where a hospital has a sufficiently large staff the utilization review committee is, as in the words of the law, comprised of 'a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel.' "

Paragraph 2515(a) of HIM-7 provides in pertinent part as follows:

"The law provides for alternative types of UR committees, where a facility does not have a sufficient number (two or more) of physicians on the house staff to serve on a UR committee."

Paragraph 2515(b) of HIM-7 provides in pertinent part as follows:

"(b) *Approval of 'Outside Utilization Review Committees*--

* * * *

Where an 'outside' committee is established by the local medical society and some or all of the facilities in the locality, no prior approval by the Secretary of Health, Education and Welfare is required. However, where the 'outside' committee is established on some basis other than under the auspices of the local medical society, the utilization review committee must have prior approval from the Secretary. The State agency should forward a complete description of the composition of the utilization review committee to the Social Security Administration. In addition, the file must be documented to show that an effort was made to constitute the committee under one of the preferred approaches and the facility should be on notice that this type of arrangement will be approved only until a more preferred method can be devised."

The "Supplemental to Chapter 8" of Health Insurance Manual 7 contains questions and answers relating to utilization review. Paragraph A on page S-1 thereof reads as follows:

"A. ORGANIZATION OF UR COMMITTEE

Q -- Former UR regulations and the law itself (1861(k) (2)) appeared to set a committee priority, with the staff committee being the preferred committee, followed by the area-wide medical society sponsored committee, and as a final choice, when neither of the above committees were established, another type of committee could be approved by the Secretary. The new regulations do not seem to imply a preference for any one of the three types. Can a large hospital elect to have an outside committee perform its UR function?

A -- Although the new regulations do not indicate the process of alternative methods of establishment of utilization review committees in detail, they should be read in conjunction with the above cited law, which gives controlling direction in this matter. *As in the past, it is the policy of BHI that the UR function be carried out by a staff committee of the hospital, and other arrangements should be accepted only where the establishment of a staff committee is not feasible. Thus, the sufficiency of the hospital medical staff to carry out UR is considered in assessing the adequacy of the UR plan. If there is a finding that the hospital medical staff does not have the capacity to effectively perform UR, then the alternates permitted by the law are considered. The Medicare Program, through the law and the regulations, has followed a policy that seeks to place responsibility for UR, whereever possible, on those physicians professionally responsible for services within the institution."* [Emphasis ours].

On October 1, 1975 in the Eastern District of Louisiana, petitioner American Association of Councils of Medical Staffs of Private Hospitals, Inc. filed suit for declaratory and injunctive relief, challenging the above provisions of HIM-7 on the following grounds:

(1) That the action of the Secretary of HEW in establishing mandatory preferences in the order of utilization review committee compositions was in excess of his statutory authority.

(2) That the challenged provisions of HIM-7 were promulgated and implemented in violation of the rulemaking requirements of the Administrative Procedure Act.

(3) That the challenged provisions of HIM-7 constitute an unreasonable interference with the physicians' right to practice their profession free of unreasonable government control, in violation of the due process clause of the Fifth Amendment to the United States Constitution.

In November, 1976 the District Court granted summary judgment for the Secretary. It ruled that under *Weinberger v. Salfi*, 422 US 749 (1975), there was no subject matter jurisdiction under 28 U.S.C. § 1331; that there was subject matter jurisdiction, however, under Section 10 of the Administrative Procedure Act; but that, on the merits, the challenged provisions of HIM-7 did not exceed the statutory authority of the Secretary of HEW, did not violate the rule-making requirements of the Administrative Procedure Act, and did not violate the Constitution of the United States.

An appeal to the Fifth Circuit Court of Appeals by petitioner followed in November, 1976. After oral argument on October 10, 1977 and the review of briefs submitted, the Fifth Circuit, in a decision entered July 7, 1978, reversed the District Court's finding of jurisdiction under the Administrative Procedure Act, refused to reverse the District Court's finding that general federal question jurisdiction was pre-

cluded by 42 U.S.C. § 1395ii as interpreted in *Salfi*, and accordingly remanded the case to the District Court for dismissal without prejudice to petitioner to file other appropriate proceedings.

Contending that the Fifth Circuit erroneously applied the holdings of *Weinberger v. Salfi*, 422 US 749 (1975) and *Califano v. Sanders*, 430 US 99 (1977) to the particular relief sought by the particular plaintiffs, petitioner has filed this Petition for Writ of Certiorari.

REASONS FOR GRANTING THE WRIT

I.

In the course of its decision, the Fifth Circuit refused to reverse the District Court's finding that no general federal question subject matter jurisdiction existed, and did reverse the finding of the District Court that subject matter jurisdiction existed under the Administrative Procedure Act. The ultimate jurisprudential authorities for those two aspects of the Fifth Circuit's decision, respectively, are *Weinberger v. Salfi*, supra, and *Califano v. Sanders*, supra. If certiorari is granted in this matter, petitioner will prove that neither the reasoning nor the holding of either case sets up a jurisictional bar to the particular relief sought by the particular plaintiffs in this matter either under the general federal question jurisdictional statute or under the Administrative Procedure Act.

The particular facts involved in *Salfi* and in *Sanders* may support the conclusions that 28 U.S.C. § 1331 and Section 10 of the Administrative Procedure Act, respectively, did not confer subject matter jurisdiction on the particular claims

made in each case. For in each of those cases, and in each and every of the reported Courts of Appeals decisions under these two cases, avenues of statutory relief or relief through administrative channels, or both, were available to the complaining parties. Further, the complaining parties were either "providers," or program beneficiaries, or other individuals for whom statutory and/or administrative channels of relief were available. The members of petitioner organization fall into none of the above categories. There are no express remedies provided within the Medicare statutes for the particular relief they seek. Neither are there any regulatory review, hearing, or appeals procedures available to the physicians for the particular relief they seek against an alleged overreach by HEW. Petitioner does not request this Court to reverse a "finding of fact" or "decision" of the Secretary of HEW but to enjoin and declare invalid a policy of the Secretary of HEW which adversely affects its members. Petitioner's members are not beneficiaries of the Medicare Program and are not persons seeking to "recover" on any claim arising under the Medicare Statutes. Petitioner's members are approximately 42,000 physicians nationwide who are adversely affected by a policy for which there is no administrative relief available. And under the theory of HEW and the Fifth Circuit, neither is there any judicial relief available. In effect, under the construction of the law given by the Fifth Circuit, doctors who are adversely affected by policies of HEW, other than under limited circumstances, have absolutely no avenue of relief available to them for the particular relief they request.

In his opening paragraph in *Califano v. Sanders*, Mr. Justice Brennan effectually created a context out of which the ultimate holding of the case simply cannot be taken. Mr.

Justice Brennan stated:

> "The questions for decision are (1) whether § 10 of the Administrative Procedure Act, 5 U.S. C. §§ 701-706 is an independent grant to district courts of subject matter jurisdiction to review *a decision of the Secretary of Health, Education and Welfare not to reopen a previously adjudicated claim for Social Security benefits* and (2) if not, whether § 205(g) of the Social Security Act authorizes judicial review of the Secretary's *decision*." [Emphasis supplied].

The Fifth Circuit, in its decision below, 575 F. 2d 1367, 1370 (Appendix A, infra, page A-19), has given an "across-the-board" effect to the holding of the Supreme Court in *Califano v. Sanders*:

> "We cannot reach the merits on this appeal: the dispositive question is whether subject matter jurisdiction existed. The district court followed this and some other Courts of Appeals by holding that jurisdiction existed under § 10 of the A.P.A., 5 U.S.C. § 701-06.... The Supreme Court has now spoken to the contrary: '[T]he [sic] APA does not afford any implied grant of subject matter jurisdiction permitting federal judicial review of agency action.' *Califano v. Sanders*, 1977, 430 S. 99, 107, 97 S.Ct. 980, 985, 51 L.Ed. 2d 192."

Respondent Sanders had administrative and judicial relief available to him. For the particular relief that they seek, the physicians have neither. The holding of the Supreme Court

in *Califano v. Sanders* and the over-broad effect given to that holding by the Fifth Circuit below overlook the existence of claims for review and relief such as petitioner placed before the District Court.

The pertinent language of the provisions of 5 U.S.C. §701-706 clearly indicates a Congressional intention to establish a right of judicial review of agency action and to grant, whether impliedly or not, subject matter jurisdiction for such review:

> "§ 701(a). This chapter applies, according to the provisions thereof, except to the extent that -
>
> (1) Statutes *preclude* judicial review,. . . [Emphasis supplied].
>
> § 702. A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, *is entitled to judicial review thereof...* Nothing herein (1) affects other limitations on judicial review or the power or duty of the court to dismiss any action or deny relief on any other appropriate legal or equitable ground, and (2) confers authority to grant relief *if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought.* [Emphasis supplied].
>
> § 703. The form for proceeding for judicial review is the special statutory review proceeding relevant to the subject matter in a court specified by statute or, *in the absence of inadequacy thereof, any applicable form of legal action, including actions for declaratory judgments or writs of prohibitory or mandatory injunction or habus corpus, in a court of competent jurisdiction. If no special statutory review proceeding is applicable, the action for judicial review may be brought against the United States, the agency by its official title, or the appropriate officer. Except to the extent that prior, adequate, and exclusive opportunity for judicial review is provided by law, agency action is subject to judicial review in civil or ciminal proceedings for judicial enforcement."* [Emphasis supplied].

It is plain from these provisions that Congress did not intend to extend or override the existing statutory grants of jurisdiction or the specific respective limitations thereto, but to provide a broad grant of judicial review *to those persons not already covered or restricted by other statutory provisions.* Section 703 even established, ". . .in the absence or inadequacy. . ." of *statutory* review relevant to a particular subject matter, a broad and all-encompassing provision allowing ". . .any applicable form of legal action. . . ."

For petitioner's members, who are not Medicare beneficiaries, and who are not Medicare providers, and who have no specific route of statutory review provided for, and who have no administrative review or hearings or appeals procedures available to them, but who are nonetheless directly and grievously affected by the actions of the Secretary complained of below, the "non-statutory review" clearly needed by those such as petitioner's members is supplied by Section 10 of the Administrative Procedure Act, as was clearly intended

by Congress.

The decision in *Califano v. Sanders*, as applied by the Fifth Circuit below, totally eliminates petitioner's right of review on the theory that Congress' amendment of 28 USC §1331 (a) eliminating the amount-in-controversy requirement as a prerequisite to maintaining federal question actions against federal agencies or officers or employees thereof undercuts the rationale for interpreting the Administrative Procedure Act as an independent jurisdictional source. This reasoning by the Supreme Court, however, would not necessarily be inconsistent with a finding that for the particular relief sought by petitioner on behalf of its members, the Administrative Procedure Act does constitute an independent source of jurisdiction. For respondent *Sanders*, there were administrative and judicial remedies available. Sanders did not avail himself of those procedures. For the Supreme Court to have found an independent source of jurisdiction in the Administrative Procedure Act would have allowed Sanders to subvert clearly defined contours of relief. For petitioner in this matter, however, there is no statutorily defined nor administrative review procedure or avenue of relief available. Under these circumstances the words of the Administrative Procedure Act quoted above should be accorded their plain meaning and given their plain effect.

The purpose of the Administrative Procedure Act was to open the courthouse doors to persons aggrieved by federal action in all instances not already provided for or limited by statute, and not simply where the amount in controversy was less than $10,000.00. Thus the removal by Congress of the $10,000.00 limitation on the availability of jurisdiction under 28 USC § 1331 should not remove the Administrative

Procedure Act as an independent grant of subject matter jurisdiction over the particular claim subject of this suit because the Administrative Procedure Act was never intended to be read *in pari materia* with 28 USC § 1331, or any other statute granting jurisdiction and a right of review, but in addition to them.

The words of Judge J. Skelly Wright, speaking for the District of Columbia Circuit Court of Appeals in *Rodway v. United States Department of Agriculture*, 514 F.2d 809, 817, (D.C. Cir., 1975) footnote 14, aptly summarize petitioner's contention in this regard, as follows:

> "In this circuit the District Court has jurisdiction under the APA to review agency action when 'there is no other adequate remedy in a court...' 5 U.S.C. § 704 (1970). See Scanwell Laboratories, Inc. v. Shaffer, 137 U.S. App. D.C. 371, 421 F.2d 859 (1970). Appellants asserted this provision as a basis for jurisdiction... and, *since the Food Stamp Act does not otherwise provide for judicial review of the Secretary's rule-making activities*, cf. 7 U.S. C. §2022, the District Court was consequently empowered by the APA to review the rules here at issue." [Emphasis supplied].

A review by this Court of its decision in *Califano v. Sanders*, for the purporse of more clearly defining the limits of its rejection of Section 10 of the Administrative Procedure Act as an independent grant of subject matter jurisdiction is plainly in the public interest as well as in the interest of petitioner since the impact of that decision, without a clear definition of its limits, is unnecessarily chilling and far-

reaching. Not only in the instant situation, but in any and all others where an innocent member of the public is directly aggrieved or injured by agency action the statutory relief from which he is denied because he doesn't "exist" within the framework of the statute, there must be an independent grant of subject matter jurisdiction for judicial review. As presently interpreted by the Fifth Circuit, and without a clearer definition of its limits by the Supreme Court, the decision in *Califano v. Sanders* removes the only such grant.

Whether or not the Administrative Procedure Act forms an independent basis of subject matter jurisdiction, general federal question jurisdiction exists for petitioner's claim under 28 U.S.C. § 1331. Unquestionably, *Weinberger v. Salfi*, supra, places limitations upon the availability of subject matter jurisdiction under Section 1331. The holding of that case, like the holding of *Califano v. Sanders*, however, must and should only be applied in the context of the limited factual situation giving rise to it. At the very least, the limited context in which the *Salfi* decision arose should not close the doors of jurisdiction on the particular claim made by petitioner in this matter. Again, members of petitioner are not providers under the Medicare Program. Neither are they beneficiaries of the Medicare Program. For both providers and beneficiaries, there are administrative procedures available. But there are no administrative review procedures available for the particular relief sought by the physicians. And under the construction of the law supplied by the Fifth Circuit below, neither is there any judicial review available. For those persons or entities for whom the Medicare Act provides specific forms of relief, resort to jurisdiction under 28 U.S.C. §1331 is not necessary. But for members of petitioner organization, unless this court finds that the Administrative Procedure Act is an independent base of jurisdiction,then

resort to Section 1331 is the only avenue of relief, administrative or judicial, that is available.

A review by this court of its decision in *Weinberger v. Salfi*, for the purpose of more clearly defining the parameters of its limitations on jurisdiction for physicians aggrieved by actions of HEW under the Medicare Program is plainly in the public interest. For under the present state of the law in the Fifth Circuit, physicians who suffer from administrative overreach in the Medicare Program simply have no forum in which to ask for relief--neither in the courts, nor in the Department of HEW.

II.

Having concluded, on the basis of *Califano v. Sanders* and the underlying constructions given to 42 U.S.C. §§ 405 (h) and 1395ii, that the Medicare Act precluded jurisdiction in district courts for actions such as petitioner's, the Fifth Circuit in its decision below (Appendix A, page A19), stated:

> "This construction of 1395ii does not end our inquiry. We must determine whether this construction totally precludes judicial consideration of claims of CMS, statutory and constitutional. *If it does, we must consider whether such preclusion itself violates the requirements of due process.*" [Emphasis supplied].

On this issue, the Fifth Circuit stated, as it had previously in *Dr. John T. McDonald Foundation v. Califano*, 5th Cir., 1977, 571 F.2d 328, that there was no need to resolve the question inasmuch as the Court of Claims had determined itself to have jurisdiction, *Whitecliff, Inc. v. United States*,

536 F.2d 347, (Ct. Claims, 1976), cert. denied 1977, 430 969, 97 S.Ct. 1652, 52 L.Ed. 2d 361, and therefore, the construction given to 42 U.S.C. § 1395ii did not totally preclude judicial review of claims such as petitioner's. But it was obvious to the Fifth Circuit in its decision below that resort to the Court of Claims could, at best, provide only a partial remedy. At page 1373, the Court stated:

> "This *particular* suit *cannot* be brought in the Court of Claims... That court cannot provide the equitable or declaratory relief sought in this suit." 575 F.2d 2367, 2737 (Appendix A, page A-29). [Emphasis supplied].

Further, that partial remedy would only be available to petitioner in the event that the Court of Claims found jurisdiction to hear petitioner's claim. A careful reading of *Whitecliff*, however, reveals sufficient differences in basic facts between the claimant therein and petitioner herein to indicate that it is far from certain that the Court of Claims would find such jurisdiction. It is interesting to note that at least one Circuit Judge on the *en banc McDonald* panel, Judge James C. Hill, had serious doubts about the correctness of the *Whitecliff* decision, as he noted in his dissent:

> "It is not judicial business to wish so earnestly that the appellant had a judicial forum that we send his case to a court which erroneously concludes that it can provide one." *McDonald*, supra, at 333.

If the opinion of Judge Hill is ultimately proven correct and it were determined that even the Court of Claims did not have jurisdiction over this claim, clearly 42 U.S.C. § 405(h)

as constructed would be violative of due process. For these reasons, petitioner finds little comfort in the suggestion by the Fifth Circuit that it seek relief through the Court of Claims.

Since the relevant portion of 5 U.S.C. §703, quoted above, clearly provides that one aggrieved by agency action may, in the absence of inadequacy of provisions for statutory review, resort to ". . . any applicable form of legal action, including actions for declaratory judgments...", even if Section 10 of the Administrative Procedure Act is not an independent grant of jurisdiction as held by this Court in *Califano v. Sanders*, it is nonetheless the codification of a *substantive right* granted to petitioner and other citizens.

There being no avenue in an action brought in the Court of Claims for petitioner to assert the substantive rights granted by the Administrative Procedure Act, if Section 10 of the Administrative Procedure Act does not act as an independent grant of jurisdiction for the assertion of these rights, then any construction of 42 U.S.C. § 1395ii which precludes petitioner's right to seek review for the purpose of declaratory, injunctive or other equitable relief must be violative of the requirements of due process. It is very much in the interest of the general public or any member thereof, and in particular for physicians who are members of petitioner, who are or may be adversely affected or aggrieved by agency action but for whom there is no judicial or administrative method of review provided for by statute or by federal regulations, that this court consider at length and in detail the constitutionality of a statute which on its face or by construction precludes the assertion of the substantive rights granted to the general public.

III.

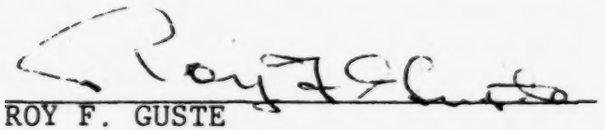
The Fifth Circuit recognized in its opinion that this action has been pending for several years and that the questions presented on the merits were substantial ones. Should this Court agree with the contentions of petitioner as to Section 10 of the Administrative Procedure Act or 28 U.S.C. §1331 or the unconstitutionality of 42 U.S.C. § 405(h) as all or any related to the particular relief requested by physicians herein, it would mean that federal judicial review of these issues would now be possible. However, to remand these issues to a lower court would also mean additional delays before resolution of these issues. Any decision on the merits of this suit reached by such lower court will certainly be the subject of a petition for another writ of certiorari to this Court, an action which will again delay the ultimate resolution of the issues.

This Court has within its power the authority to either remand to a lower court for further proceedings consistent with its opinion or to proceed to a complete decision on the merits of the entire matter where justified. *Cole v. Ralph*, 252 US 286, (1919). Because of the constitutional questions presented by the main action and the intrinsic importance to the general public, as well as to petitioner, of the question of the Secretary's, or any other administrative functionary's, ability to override, amend, circumvent or supersede his authority as granted by Congress, petitioner suggests that this Court should avoid further unnecessary delays by proceeding to a complete decision on the merits of petitioner's action after determination of the jurisdictional issues presented in this petition for writ of certiorari.

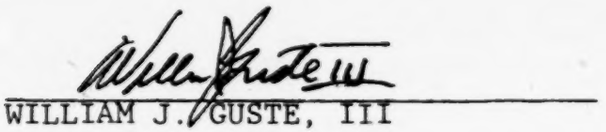
CONCLUSION

For the reasons stated herein, this petition for writ of certiorari should be granted.

Respectfully submitted,

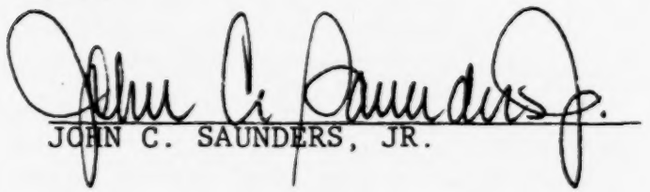


ROY F. GUSTE



WILLIAM J. GUSTE, III

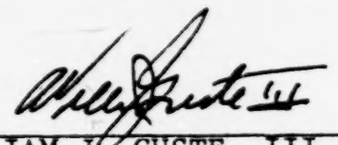
and



JOHN C. SAUNDERS, JR.

PROOF OF SERVICE

I, WILLIAM J. GUSTE, III, one of the attorneys for The American Association of Councils of Medical Staffs of Private Hospitals, Inc., and a member of the Bar of the Supreme Court of the United States, hereby certify that, on the 2nd day of October, 1978, I served copies of the foregoing Petition for Writ of Certiorari on the Secretary of Health, Education and Welfare through the United States Solicitor General, Department of Justice, Washington, D.C. 20530.



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APPENDIX A

OPINIONS BELOW

The AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.

v.

David MATHEWS.

Civ. A. No. 75-3061

United States District Court, E. D. Louisiana

Oct. 12, 1976

HEEBE, Chief Judge:

Plaintiff brings this action against the Secretary of Health, Education, and Welfare (Secretary) for declaratory and injunctive relief from certain provisions of an instructional manual published by the Social Security Administration, Department of Health, Education, and Welfare (HEW). The challenged provisions relate to utilization review requirements medical facilities must satisfy in order to participate in the federal medicare program established by subchapter XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.* Plaintiff alleges that the manual provisions at issue exceed the statutory authority granted to the Secretary by the Social Security Act, were promulgated in violation of the Administrative Procedure Act, and are unconstitutional. Defendant denies plaintiff's allegations and contends that we lack jurisdiction over the subject matter and that plaintiff lacks stand-

ing. The case is now before the Court on cross motions for summary judgment. We hold that plaintiff has standing to bring this action and that we have jurisdiction to hear it under Section 10 of the Administrative Procedure Act, 5 U.S.C. §701 *et seq.* We further hold that on the merits summary judgment must issue in favor of defendant.

BACKGROUND

In 1965 Congress enacted Title XVIII of the Social Security Act, commonly known as the Medicare program. 42 C. §1395 *et seq.* This legislation establishes a federal reimbursement scheme for funding beneficiaries' covered health costs. Payment on behalf of these beneficiaries can only be made to "providers of services" defined in 42 U.S.C. § 1395x (u) as hospitals, skilled nursing facilities, and home health agencies. 42 U.S.C. §1395f(a). In order to meet the definition of a hospital or skilled nursing facility within the term "provider of services", an institution must, *inter alia*, have in effect a utilization review [1] plan which meets the requirements of 42 U.S.C. §1395x(k). Once an institution has met the definition of a provider of services it is qualified to participate in the Medicare program and is eligible to receive Medicare payments as specified in 42 U.S.C. §1395cc(a)(1). This agreement may be terminated by the Secretary when such an institution ceases to maintain a sufficient utilization review plan. 42 U.S.C. §1395cc(b)(2).

1. Utilization review entails the review of admissions to an institution, the duration of says therein, and the professional services furnished. The review committee evaluates the medical necessity of the admissions, stays, and care provided for the purpose of promoting the most efficient use of available health facilities and services. 42 U.S.C. §1395 x(k) (1).

Utilization review is conducted by committees the composition of which is prescribed by § 1395x(k). According to that section review apparently may be conducted by either a staff committee of the institution or by a group outside the institution.[2] The language of Section 1395x(k) is tracked by 20 C.F.R. § 405.1035(e), [3] promulgated by the Secretary pursuant to his authority to make and publish such rules and regulations as may be necessary to the efficient administration of the functions with which he is charged. 42 U.S.C. § 1395hh.

Plaintiff does not challenge the above statute and regulation which, plaintiff maintains, make staff and non-staff review committees equally available to hospitals. Instead, plaintiff's challenge is directed to the utilization review provisions of the State Operations Manual, also known as Health Insurance Manual 7 (HIM7).[4] HIM7 indicates a preference between the available options for composition of utilization review committees, to wit, review must be conducted by a staff (in-house) committee where a facility has a sufficient number (two or more) of physicians on the house staff to serve on a utilization review committee. The utilization re-

2. 42 U.S.C, §1395x(k) provides in pertinent part:

> (k) A utilization review plan . . . shall be considered sufficient . . . if it provides-. . .
> (2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians . . . or (B) a group outside the institution which is similar composed.

3. 20 C.F.R. § 405.1035(e)(1) states:

> The utilization review function is performed by a staff committee of the hospital composed of two or more physicians . . . or by a group outside the hospital which is similarly composed. . .

4. HIM7 was issued by HEW in order to provide guidance to state agencies making determinations as to the sufficiency of the utilization review plans of particular institutions.

view function may be carried out by a non-staff committee only where the establishment of a staff committee is not feasible. Plaintiff deems this preference for staff review undesirable and invalid.

JURISDICTION

Plaintiff alleges jurisdiction under 28 U.S.C. § 1331 (general federal question jurisdiction) and Section 10 of the Administrative Procedure Act, 5 U.S.C. §701 *et seq.* The Secretary contends that 42 U.S.C. § 405(h) precludes jurisdiction under both § 1331 and the Administrative Procedure Act.

With regard to plaintiff's allegations of jurisdiction under § 1331 we are bound to follow *Gallo v. Mathews*, 534 F.2d 1137 (5th Cir. 1976). *Gallo* explicitly held that the Supreme Court's interpretation of § 405(h) [5] in *Weinberger v. Salfi*, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522 (1975), precludes §1331 jurisdiction in cases asserting any claim arising under the Medicare Act even if that Act provides plaintiff with no route for judicial review of his claim.[6] Accordingly,

5. 42 U.S.C. § 405(h), relating to Social Security claims but expressly made applicable to the Medicare program by 42 U.S.C. § 1395ii, provides in pertinent part:

> . . .No action against the United States, the Secretary, or any officer or employee thereof shall be brought under (28 U.S.C. § 1331 *et seq.*) to recover on any claim arising under this subchapter.

6. *Salfi* apparently held that §405(h) on its face bars §1331 jurisdiction, including constitutional challenges, in suits to recover Social Security benefits. Until *Gallo*, however, the Fifth Circuit had not decided whether § 1331 jurisdiction survived *Salfi*. While *Lejeune v. Mathews*, 526 F.2d 950 (5th Cir. 1976), intimated that it read *Salfi's* interpretation of the third sentence of §405(h) to negate § 1331as a possible source of jurisdiction, 526 F.2d at 953 n.2, *Dr. John T. Mac Donald Foundation, Inc. v. Mathews*, 534 F.2d 633 (5th Cir. 1976),

we find that plaintiff lacks jurisdiction under § 1331.

We agree with plaintiff, however, that jurisdiction exists under the Administrative Procedure Act. In substance, that act provides courts with jurisdiction over a) agency action, b) which is final, c) which injures a person, and d) for which there is otherwise no adequate judicial remedy.[7] An "agency action" includes any "rule," defined as an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy. 5 U.S.C. § § 551(4), 551(13). HIM7 clearly constitutes agency action within the meaning of the Administrative Procedure Act.

Neither is there any doubt that the promulgation, publication, and enforcement of HIM7 constitutes "final" agency

(Footnote 6 - continued)

without deciding the issue, disagreed indicating that it considered the issue unresolved. *MacDonald* noted that in *Salfi* review was sought for an order that was judicially reviewable under § 405(g). A decision that § 405(h) operates as an absolute bar to § 1331 jurisdiction was not necessary to the holding in *Salfi*, since the Court found jurisdiction under the Social Security Act. Therefore, until *Gallo*, it could have been argued that *Salfi* was entirely consistent with prior jurisprudence, e.g. *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 667 (2d Cir. 1973 ,)which held that review is available under § 1331 where the Medicare or Social Security Acts provide no procedure for judicial review. Plaintiff is now foreclosed from so arguing.

7. Section 10(a)bf the Administrative Procedure Act, 5 U.S.C. § 702 provides:

> A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof.
>
> Section 10(c), 5 U.S.C. § 704 further provides Agency action made reviewable by statute and final agency action for which there is no adequate remedy in a court are subject to judicial review.

action. *National Automatic Laundry and Cleaning Council v. Schultz*, 143 U.S. App. D.C. 274, 433 F.2d 689 (1971). See *Abbott Laboratories v. Gardner*, 387 U.S. 136, 87 S.Ct. 1507, 18 L.Ed.2d 681 (1967). The process of rule-making is complete; the provisions of the manual are definitive.

Plaintiff has alleged the requisite injury as in demonstrated in our discussion on STANDING, infra.

Finally, we conclude that plaintiff possesses no other adequate judicial remedy despite the Secretary's assertion that § 1395ff(c) [8] of the Medicare Act prescribes procedures for a hearing and for judicial review of plaintiff's claim. The pertinent part of section 1395ff(c) applies only to an institution or an agency dissatisfied with any determination by the Secretary that it is not a provider of services. Assuming the validity of the Secretary's argument that this motion concerns a determination of the status of certain hospitals as providers of services within § 1395ff(c), we nevertheless decide that plaintiff's claim is outside the purview of that section. The right to hearing and judicial review granted by § 1395ff(c) is limited to *institutions or agencies*, and is not available to plaintiff organization.

Defendant next contends that 42 U.S.C. § 405(h) [9] limits jurisdiction over Medicare claims to the jurisdictional grants

8. 42 U.S.C. § 1395ff(c) provides:

> Any institution or agency dissatisfied with any determination by the secretary that it is not a provider of services . . .shall be entitled to a hearing thereon by the Secretary . . . to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

9. 42 U.S.C. §405(h), provides in pertinent part:

contained in the Medicare Act and, thus, precludes jurisdiction under the Administrative Procedure Act.[10] This argument has been considered and rejected by the Fifth Circuit. The effect of §405(h) on jurisdiction over Medicare claims under the Administrative Procedure Act has been settled in the Fifth Circuit since *Ortego v. Weinberger*, 516 F.2d 1005 (5th Cir. 1975). The *Ortego* court adopted relevant Second Circuit jurisprudence which concluded:

> Where an act provides procedures for judicial review, a court cannot review an agency decision by any other means; where the act does not provide such procedures, however, "nonstatutory" (Administrative Procedure Act) review is still available.

516 F.2d at 1009, *citing Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971).

As noted by *Ortego*, a presumption of reviewability exists under the Administrative Procedure Act. A statute must demonstrate clear and convincing evidence of an intent to preclude judicial review before courts will cut off an aggrieved party's right to be heard *Abbott Laboratories v. Gardner*, 397 U.S. 136, 87 S.Ct. 1507, 18 L.Ed. 2d 681 (1976). Here, § 405(h) does not preclude such review because by its terms

(Footnote 9 continued)

> The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any tribunal . . . except as herein provided . . .

The remainder of § 405(h) is set out in note 5, supra.

10. Predictably, the judicial review provisions of the Administrative Procedure Act are inapplicable to the extent that statutes preclude judicial review. 5 U.S.C. § 701.

it applies only to determinations made after a hearing. As we have already noted, the Medicare Act provides no procedure for affording plaintiff a hearing on its claim.

The Secretary finally argues that *Weinberger v. Salfi, supra,* nullifies the *Ortego* view of § 405(h). We are not persuaded by this argument. *Salfi* was considered by *Ortego,* 516 F.2d at 1011 n. 4 and we are bound by the Fifth Circuit's interpretation of that case. Moreover, *Lejeune v. Mathews,* 526 F.2d 950 (5th Cir. 1976) also considered *Salfi* and found that decision to be inapposite to cases, such as this, where the Medicare Act provides plaintiff with no route for judicial review. See also *Dr. John T. MacDonald Foundation v. Mathews,* supra.

STANDING

Standing under the Administrative Procedure Act is conferred upon those who can show that the challenged action has caused them injury in fact, and that the alleged injury was to an interest arguably within the zone of interests to be protected or regulated by the statute that the agencies are claimed to have violated. *Sierra Club v. Morton,* 405 U.S. 727, 92 S.Ct. 1361, 31 L.Ed.2d 636 (1972); *United States v. SCRAP,* 412 U.S. 669, 93 S.Ct. 2405, 37 L.Ed.2d 254 (1973). An organization whose members are injured may represent those members in a proceeding for judicial review. 405 U.S. at 727, 92 S.Ct. 1361.

We find the complaint sufficient to establish the standing of plaintiff. *American Medical Association v. Weinberger,* 395 F.Supp. 515 (N.D. Ill. 1975). The physician members of the American Association of Medical Councils allege that the

utilization provisions of HIM7 unlawfully interfere with the doctor-patient relationship and the right of a physician to practice medicine according to his best medical judgment. Specifically, it is alleged that the conduct of the utilization review places the doctors in a conflict of interests with fellow members of their medical staffs. Utilization review requires the reviewing physicians to make decisions which cause patients of their fellow physicians to be discharged from the hospital prior to the time when the treating physicians would have discharged those patients. Additionally, plaintiff argues that physicians are taken away from their daily practice and the treatment of their patients in order to perform utilization review functions. These allegations assert perceptible harm within the meaning of *SCRAP,* supra.

Moreover, these allegations reflect interests arguably within the zone of interest sought to be regulated or protected. The Medicare Act was intended, in part, to improve the quality of medical care. If plaintiff's allegations are true the challenged provisions of HIM7 are preventing plaintiff's member physicians from rendering the medical care which they, in their professional judgment, deem necessary. Furthermore, Section 1801 of the Social Security Act, 42 U.S.C. § 1395, forbids any federal officer or employee from exercising any supervision or control over the practice of medicine. Plaintiff alleges that the challenged provisions embody supervision or control over the practice of medicine forbidden by the enabling statute.

AUTHORITY OF THE SECRETARY

Plaintiff maintains that by promulgating HIM7 the Secretary exceeded the authority vested in him by Congress since

the utilization review provisions of that manual contradict the language and intent of 42 U.S.C. § 1395x(k) and of 20 C.F.R. § 405.1035(e). Specifically, it is argued that the preference for in-house review manifested by HIM7 contradicts the statute and the regulation, neither of which contains any indication that staff committees are preferable to non-staff committees. We disagree.

As stated by the Supreme Court in *Mourning v. Family Publications Service*, 411 U.S. 356, 93 S.Ct. 1652, 36 L.Ed. 2d 318 (1973):

> The standard to be applied in determining whether the (Secretary) exceeded the authority delegated to (him) . . . is well established . . . Where the empowering provision of a statute states simply that the agency may "make . . such rules and regulations as may be necessary to carry out the provisions of this Act," we have held that the validity of a regulation promulgated thereunder will be sustained so long as it is "reasonably related to the purposes of the neabling legislation."

411 U.S. at 369, 93 S.Ct. at 1660. The empowering provision of the Social Security Act, 42 U.S.C. § 1302, contains language similar to the statute discussed in *Mourning* and, thus requires the agency's manual[11] to be reasonably related

11. The standard of review is not altered because plaintiff challenges the provisions of a manual rather than a regulation. *Thorpe v. Housing Authority*, 393 U.S. 268, 89 S.Ct. 518, 21 L.Ed.2d 474 (1969). In *Thorpe* the Supreme Court considered the validity of requirements imposed in a circular issued by the Department of Housing and Urban Development (HUD). The challenged circular was the initial promulgation of a forthcoming change to be incorporrated in HUD's Low Rent Management Manual. Applying essentially the same standard of review

to the purpose of the enabling legislation. *Johnson's Professional Nursing Home v. Weinberger*, 490 F.2d 841 (5th Cir. 1974), *affirming*, *Opelika Nursing Home, Inc. v. Richardson*, 356 F.Supp. 1338 (M.D. Ala. 1973).

Nothing in the statutory scheme or in the statutory history[12] indicates that Congress meant to preclude the estab-

(Footnote 11 - continued)

later explicitly adopted by *Mourning*, 411 U.S. at 369, 93 S.Ct. 1652, the Court found the provisions of the circular to be consistent with and reasonably related to the purposes of the enabling legislation under which it was promulgated.

We note the existence of authority which supports the proposition that an interpretative rule such as HIM7--interpretive rules and substantive regulations are defined in COMPLIANCE WITH ADMINISTRATIVE PROCEDURE ACT, infra -- promulgated without public participation in the rule-making process is entitled to less deference than a substantive regulation. E.G., *Pacific Gas & Electric Co. v. Federal Power Commission*, 164 U.S. App. D.C. 371, 506 F.2d 33(1974). The rationale is that absent full public participation in rule making, which is only required for the validity of substantive regulations, judicial review may be the first stage at which the policy of a rule is subjected to full criticism by interested parties. Moreover, an interpretive rule does not have the force of law. *Pacific Gas & Electric Co., supra. See generally* K. Davis, Administrative Law Treatise § 5.01 *et seq.* (1958, Supp. 1970). In any event, the application of a standard of review which gives us more leeway to assess the underlying wisdom of the interpretive rule would produce no change in our result. HEW's expertise can n ot be ignored, particularly since judgments on the soundness of mandatory staff review lie beyond judicial competence. Additionally, the policy of preference for staff review has been in effect since 1968 and Congress has not chosen to alter it. *See Cory Corp. v. Sauber*, 363 U.S. 709, 712, 80 S.Ct. 1331, 4 L.Ed.2d 1508 (1960). Although we may be free to substitute our judgment for that of HEW we decline to do so. Instead, we elect to adopt the rule in question as a correct interpretation of the statute.

12. Portions of the relevant legislative history cited by both plaintiff and defendant are ambiguous and shed little light on the Congressional intent regarding the preferred composition, or lack thereof, of utilization review committees. S. Rep. No. 404, 89th Cong. 1st Sess. (1965).

lishment of a staff-preference policy. On the contrary, support may be found for the Secretary's interpretation of the Congressional intent underlying 42 U.S.C. §1395x(k).

During Congressional hearings conducted prior to the passage of the original Medicare legislation, Robert M. Ball, Commissioner of the Social Security Administration, testified as follows before the House Ways and Means Committee:

> The utilization review committee . . would ordinarily be a a committee of the staff physicians in a given hospital. That would be the major way. Now, there is an alternative in case it is a very small hospital, so you would not have enough doctors on the staff to make it reasonable to set up a committee . . . The utilization review would be, as I say, almost always the physicians who are staff members of that hospital.

Executive Hearings on H.R. 1 and Other Proposals for Medical Care for the Aged Before the House Committee on Ways and Means, 89th Cong., 1st Sess., pt. 1, at 50 (1965). (1965 Hearings.)

(Footnote 12 - continued)

pp. 1943, 1988, for example, provides in part:

> Hospitals and extended care facilities participating in the program would be required to have in effect a utilization review plan . . The review would *ordinarily* be carried out by a staff committee of the institution . . *Alternatively,* the review could be conducted by a similar group outside the institution. (Emphasis added.)

The use of the terms "ordinarily" and "alternatively" is contradictory. By the former term the Senate Finance Committee anticipates with approval that review will be performed by staff committees as a general practice and thereby implies a preference for staff committees; by the latter term the committee designates staff and non-staff committees as two options either of which may be chosen.

Assistant Secretary of Health, Education, and Welfare, Wilber J. Cohen, further reinforced the correctness of the Secretary's view that the bill was intended to provide for utilization review by non-staff committees only where the size of the staff makes staff review impracticable. Cohen explained the purpose of including in the bill the non-staff committee alternative, which presently appears as 42 U.S.C. §1395x(k)(2)(B((i):

> This problem of the small hospital in communities . . . small hospital with only three or four doctors, presented us with quite a problem. We have written in here for those smaller hospitals where the two or three doctors don't want to be just be reviewing their own cases on each other . . .

1965 Hearings at 107.

Those who attack an administrator's interpretation of a statutory scheme as inconsistent with the purpose of the enabling legislation bear a heavy burden. HEW's expertise in the area of its authority entitles it to considerable deference. *Johnson's Professional Nursing Home v. Weinberger, supra.* The Secretary has determined that the avowed Congressional purpose of utilization review -- to promote the most efficient use of health care facilities and services, 42 U.S.C. § 1395x(k)(1) is best effectuated by placing the responsibility of review on doctors responsible for services within the treating institution. There are no compelling indications that this policy conflicts with a reasonable interpretation of 42 U.S.C. §1395x(k) or 20 C.F.R. 405,1035(e).[13] It, there-

13. Plaintiff cites 42 U.S.C. §1320, the Medicare Deadline Amendments Bill, in support of its position. Section 1320 established Professional Standards Review Organizations (PSRO's) to review the quality and necessary of health services provided under the medicare and medicaid programs. PSRO's can delegate their review responsibilities

fore, should be followed. See *Red Lion Broadcasting Co. v. F.C.C.*, 395 U.S.367, 381, 89 S.Ct. 1794, 23 L.Ed.2d 371 (1969). Accordingly, we conclude that the Secretary did not exceed the authority vested in him by 42 U.S.C. § 1302.

COMPLIANCE WITH ADMINISTRATIVE PROCEDURE ACT

Plaintiff claims that HIM7 is not an interpretative rule but a substantive regulation which is invalid because the Secretary failed to give prior notice and opportunity for comment as required by Section 4 of the Administrative Procedure Act, 5 U.S.C. §533.[14] The Secretary contends that HIM7 is an interpretative rule which is excluded from the notice requirements of the Administrative Procedure Act by §553(b)(3)(A).

(Footnote 13 - continued)

to hospital review committees or carry out review activities on their own if a hospital cannot conduct satisfactory review of chooses that the PSRO perform the review for it. On the basis or this statute plaintiff would have us conclude that Congress has evidenced an intent to allow hospitals to delegate utilization review functions to non-staff committees. This argument is unavailing. Whether a hospital can refuse to use its utilization review machinery to conduct review for a PSRO is unrelated to the inquiry of whether a hospital can delegate utilization review functions to a non-staff committee. Utilization review and professional standards review are separate and distinct functions; the former operates on an institution by institution basis while the latter operates as a nationwide program of utilization review. *See Association of American Physicians and Surgeons v. Weinberger*, 395 F.Supp. 125 (N.D.Ill. 1975).

14. 5 U.S.C. §553 requires general public notice of rulemaking proceedings and an opportunity for interested persons to "participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation."

The distinction between interpretative rules and substantive regulations issued by administrative agencies is easily verbalized. An interpretative rule is a clarification or explanation of existing laws or regulations rather than a substantive modification in or adoption of new regulations. Substantive regulations create law whereas interpretative rules are statements as to what the administrative officer thinks the statute or regulation means. *Continental Oil Co. v. Burns*, 317 F.Supp. 194 (D. Del. 1970). *See also* 1 K. Davis, Administrative Law Treatise § 5.01 *et seq.* (1958, Supp. 1970). Applying these definitions to particular agency rules, however, presents a more difficult task.

As stated in *Pharmaceutical Manufacturers Association v. Finch*, 307 F.Supp. 858 (D.C.Del. 1970) the determination that a rule or regulation is subject to the notice and comment provisions of Section 4 of the Administrative Procedure Act should be based upon the basic purpose of the statutory requirements rather than upon facile semantic distinctions.

> The basic policy of Section 4 at least requires that when a proposed regulation of general applicability has a substantial impact on the regulated industry. .notice and opportunity for comment should first be provided.

307 F.Supp. at 863. This "substantial impact" test was announced by a three-judge court in *National Motor Freight Traffic Assn. v. United States*, 268 F.Supp. 90 (D.D.C. 1976)aff'd 393 U.S. 18, 89 S.Ct. 49, 21 L.Ed.2d 19 (1968) and frequently has been followed. *See, e.g., Commonwealth of Pennsylvania v. United States*, 361 F.Supp. 208 (M.D. Penn. 1973); *Continental Oil Co. v. Burns, supra.*

We are of the opinion that HIM7 is an interpretative rule

having no "substantial impact" on plaintiff and as such was not subject to the notice and opportunity for comment provisions of the Administrative Procedure Act. The utilization review provisions of HIM7 are not a complex and all pervasive set of regulatory matter. Rather, they merely represent an attempt to clarify or define the nature of the utilization review committees required by §1395x(k) and by 20 C.F.R. § 405.1035(e). No drastic change in the existing law is effected by making explicit a preference for staff committees consistent with and, in fact, intended[15] by that law. *See Garelick Mfg. Co. v. Dillon*, 114 U.S. App.D.C. 218, 313 F. 2d 899 (1963).

CONSTITUTIONALITY

Finally, plaintiff contends tht the challenged provisions of HIM7 constitute unreasonable governmental interference with the right of doctors to practice medicine, in violation of the Fifth Amendment. We find this argument to be without merit. The disputed provisions of the manual proclaim a policy which is reasonably related to a legitimate governmental purpose and which does not act upon plaintiff's members in such a mandatory fashion as to amount to an unconstitutional interference.

The Federal government has the right to regulate that which it subsidizes. *Wickard v. Filburn*, 317 U.S. 111, 63 S.Ct. 82, 87 L.Ed. 122 (1942). Plaintiff does not deny that some form of utilization review is necessary in order to avoid over-utilization of health care services and to achieve more

15. *See* testimony of Robert M. Ball and Wilber J. Cohen given at the 1965 Hearings, *supra*.

effective control over the costs of those services.[16] Utilization review is instrumental in enforcing certain standards which must be met as a prerequisite for the dispensation of federal funds. The policy of requiring hospitals having two or more physicians on their staffs to conduct in-house-review while allowing smaller hospitals and extended care facilities to utilize non-staff review is an attempt to increase the effectiveness of utilization review and clearly is a legitimate exercise of government regulation. *Association of American Physicians and Surgeons v. Weinberger*, 395 F.Supp. 125 (N.D. Ill. 1975); *Rasulis v. Weinberger*, 502 F.2d 1006 (7th Cir. 1974); *Fleming v. Nestor*, 363 U.S. 603, 80 S.Ct. 1367, 4 L.Ed.2d 1435 (1960).

The policy of preference for staff committees where feasible does not regulate the *practice* of medicine. Rather, it regulates the procedures which *hospitals* and *extended care facilities* must follow to obtain government medicare funds. The preference policy does not prohibit any physician from rendering whatever treatment he deems necessary in the exercise of his professional judgment.[17] Plaintiff cannot

16. Plaintiff does not question the constitutionality of utilization review in general, but only of HIM7's preference for staff review.

17. Utilization review does not prevent the treating physician from keeping his patient in the hospital as long as he desires or from prescribing whatever drugs he wishes for as long as he deems necessary. However, a determination by the review committee that certain treatment is excessive will prevent the institution from receiving federal medicare funds for the surplus medical care. Such regulation has, at best, an indirect effect on the physician's practice of medicine which must be tolerated in order to prevent the over-utilization of medical facilities and services.

Furthermore, we are unable to understand plaintiff's contention that utilization review conducted by staff doctors is a greater burden on the

be heard to complain because some staff physicians must devote part of their time to utilization review.[18] Such is the price exacted for the opportunity to receive government funds which the participating hospitals and the doctors practicing at those hospitals otherwise would not have received. Hospitals are not required to participate in the medicare program and doctors are not required to practice at hospitals which qualify as providers of services. Certainly, an economic incentive to participate in the program exists. However, such inducement is not tantamount to coercion. *Association of American Physicians and Surgeons v. Weinberger, supra; Steward Machine Co. v. Davis*, 301 U.S. 548, 57 S.Ct. 883, 81 L.Ed. 1279 (1937).

For the foregoing reasons, plaintiff's motion for summary judgment is denied. Defendant's motion for summary judgment is granted. Let judgment be entered accordingly.

(Footnote 17 - continued)

on the practice of medicine than non-staff review (to which plaintiff has no objection). Plaintiff has not explained why a doctor on the staff of a hospital would be more likely than an "outside" physician to deem treatment prescribed by fellow staff doctors excessive.

18. The implementation of non-staff review desired by plaintiff would produce more displeasure among reviewing physicians than the present system of staff review. If doctors on the staffs of hospitals do not wish to perform the review necessary for the institutions at which they practice to receive federal funds, it is reasonable to assume that non-staff doctors would be even less willing to conduct review for institutions at which they do not practice.

The AMERICAN ASSOCIATION OF COUNCILS OF MEDICAL STAFFS OF PRIVATE HOSPITALS, INC.,
Plaintiff-Appellant,

v.

Joseph A. CALIFANO, Jr., Secretary of U.S. Department of Health, Education and Welfare, Defendant-Appellee.

No. 76-4156

United States Court of Appeals, Fifth Circuit

July 7, 1978

Appeal from the United States District Court for the Eastern District of Louisiana.

Before WISDOM, GEWIN and AINSWORTH, Circuit Judges.

WISDOM, Circuit Judge:

The American Association of Councils of Medical Staffs of Private Hospitals (CMS) filed suit on behalf of its physician members challenging certain federal regulations. These regulations, promulgated under the Medicare Act, 42 U.S.C. § 1395 et seq., control the manner in which participating hospitals review their physicians' efforts. The district court held that it had jurisdiction, and found against the plaintiff-appellant on the merits. We find there is no subject matter jurisdiction, and vacate the judgment below without prejudice to CMS to file other appropriate proceedings.

I.

Title XVIII of the Social Security Act establishes the Medicare program. Part A of that program provides hospital insurance for the aged and certain disabled individuals of any age. The government undertakes to reimburse authorized "providers of services" for a covered beneficiary's health costs. These providers include hospitals, skilled nursing facilities, and home health agencies, but not individual physicians. 42 U.S.C. §1395x(u).

Congress feared that the existence of a federal blank check would lead providers to use their resources inefficiently. To avoid that, the Act requires that each hospital or skilled nursing facility must have in effect a "utilization review plan" to qualify as a provider. 42 U.S.C. § 1395x(e)(6), (j) (8). A "sufficient" plan reviews the admissions to a facility, the duration of stays, and the professional services, including drugs, furnished the patients to determine both the medical necessity for the actions and their effects on the efficiency of the facility. The statute specifies the composition of the reviewing group.

> "(k) A utilization review plan . . . shall be considered sufficient. . . if it provides (2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been such a group which serves such institution, which is established

> in such other manner as may be approved by the Secretary . . .."

42 U.S.C. §1395x(k). If the institution is very small or lacks an organized medical staff, the review must be accomplished by the outside group or other method allowed in subsection (B). 42 U.S.C. §1395x(k).

The Secretary of Health, Education, and Welfare has the authority to promulgate necessary regulations for the Medicare Act. 42 U.S.C. § 1395hh. The Secretary is given the power to authorize state health agencies to determine whether a facility may participate in Medicare as a provider. 42 U.S.C. § 1395aa(a). Under his general authority to promulgate regulations, the Secretary defined the composition of the review body in the alternative ways used by the statute. 20 C.F.R. § 405.1035(e)(1). In order to guide state agencies in their eligibility determinations, the Department's Bureau of Health Insurance produced the "State Operations Manual" known as HIM-7. Unlike the statute, and unlike the regulation, the section defining utilization review plans in HIM-7 specifies a preferred alternative.

> "2510(a) *In-House Committees* ---Typically and preferably when a hospital has a sufficiently large staff the utilization review committee is, as in the words of the law, comprised of, 'a staff committee of the institution composed of two or more physicians with or without the participation of other professional personnel.' "

HIM-7 acknowledged that the law provides an alternative, but authorizes that alternative only in limited situations.

> "The law provides for alternate types of UR committees, where a facility does not have a sufficient number (two or more) of physicians on the house staff to serve on a UR committee."

HIM-7, §2515(a). Section 2515(b) establishes a preference for smaller facilities to use outside committees sponsored by medical societies, rather than some "other manner as may be approved by the Secretary". Furthermore, that section advises state agencies to inform the facilities that any other plan is acceptable only until one of the preferred methods can be devised.

That mandate of the Secretary sparked this law suit. The composition of the utilization review committee must be approved, or the facility will not be an authorized "provider". Without authorization, the government will not reimburse it for any services provided to patients otherwise eligible for Medicare. Provider status is essential to most American private hospitals. CMS, representing doctors at private institutions, disapproves of the preferred method of review. It believes that in-house review committees waste physician time and lead to conflicts, ethical and personal, within the staff.

On October 1, 1975, CMS filed suit for declaratory and injunctive relief in the Eastern District of New Orleans. CMS pressed three arguments. It urged that the Secretary had no power to establish mandatory preferences among the methods allowed by the statute. It maintained that HIM-7 was promulgated in violation of the rule-making requirements of the Administrative Procedure Act. It argued that the requirement violated the doctors' due process rights, protected by the fifth amendment. The Secretary moved to dismiss;

CMS moved for summary judgment. After a hearing on the motions, the district court granted summary judgment for the Secretary in November 1976. The trial court found that it had jurisdiction under §10 of the Administrative Procedure Act. The court held that the regulation was not inconsistent with the statute; that it was an interpretive rule, outside the restrictions of the A.P.A.; and held that no constitutional violation existed. This appeal followed.

II.

We cannot reach the merits on this appeal: the dispositive question is whether subject matter jurisdiction existed. The district court followed this and some other Courts of Appeals by holding that jurisdiction existed under §10 of the A.P.A., 5 U.S.C. §701-06. *See Ortego v. Weinberger*, 5 Cir. 1975, 516 F.2d 1005; *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 5 Cir. 1976, 534 F.2d 633, *modified on rehearing*, 1977, 554 F.2d 714, *rev'd en banc*, 1978, 571 F.2d 328; *Bradley v. Weinberger*, 1 Cir. 1973, 483 F.2d 410; *Deering Milliken, Inc. v. Johnston*, 4 Cir. 1961, 295 F.2d 856; *Sanders v. Weinberger*, 7 Cir. 1975, 522 F.2d 1167, *rev'd sub nom., Califano v. Sanders*, 1977, 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192; *Brandt v. Hickel*, 9 Cir. 1970, 427 F.2d 53; *Brennan v. Udall*, 10 Cir. 1967, 379 F.2d 803; *Pickus v. United States Board of Parole*, 1974, 165 U.S.App. D.C. 284, 507 F.2d 1107. The Supreme Court has now spoken to the contrary: "[T]he APA does not afford an implied grant of subject-matter jurisdiction permitting federal judicial review of agency action". *Califano v. Sanders*, 1977, 430 U.S. 99, 107, 97 S.Ct. 980, 985, 51 L.Ed.2d 192.

The district court held that general federal question jurisdiction was precluded by 42 U.S.C. § 1395ii. To find juris-

diction, we would have to reverse that holding.

The Medicare Act does not have its own section precluding judicial review. Instead, § 1395ii incorporates 42 U.S.C. § 405(h), which precludes review of decisions under Title II of the Social Security Act. That section reads:

> "The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. *No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.*"

[emphasis added] 42 U.S.C. § 405(h). Title II provides administrative and judicial review of the matters covered by § 405(h) through § 405(g). The Medicare Act incorporated § 405(h), precluding review, totally; it incorporated § 405(g), providing review, on ly in part.

> "Any institution or agency dissatisfied with any determination by the Secretary that it it not a provider of services, or with any determination described in section 1395cc(b)(2) of this title [concerning termination by the Secretary of certain agreements], shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title."

42 U.S.C. § 1395ff(c). *See also* 42 U.S.C.A. § 1395oo(f) (West Supp. 1377) (added in 1974).

The question of review of decisions apparently precluded by § 1395ii has been considered by several courts. The cases however have always been slightly different from this case. They have involved actions by providers complaining of reimbursement decisions and procedures. The Court of Claims ruled that it had jurisdiction as to questions of law and constitutional claims under 28 U.S.C. § 1491. *Whitecliff, Inc. v. United States*, Ct. Cl. 1976, 536 F.2d 347, *cert. den.* 1977, 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361. The Court of Appeals for the Eighth Circuit held that it had jurisdiction over constitutional issues only. *St. Louis University v. Blue Cross Hospital Service*, 8 Cir. 1976, 537 F.2d 283, *cert. den.* 1977, 429 U.S. 977, 97 S.Ct. 484, 50 L.Ed.2d 584. In the Second and Seventh Circuits the Courts of Appeals have held that they have no jurisdiction, but that the Court of Claims does. *South Windsor Convalescent Home, Inc. v. Mathews*, 2 Cir. 1976, 541 F.2d 910; *Trinity Memorial Hospital of Cudahy, Inc. v. Associated Hospital Service, Inc.*, 7 Cir. 1977, 570 F.2d 660.[1]

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1. The District of Columbia Circuit has also held that subject matter jurisdiction does not attach to claims under the Medicare Act. *Ass'n of American Medical Colleges v. Califano*, 1977, 186 U.S.App.D.C. --, 569 F.2d 101. That case, however, involved a provider's claim for reimbursement and was brought after the amendments to § 1395oo created administrative and judicial review of such claims. Therefore, that Court did not face a situation where denial of federal question jurisdiction might preclude any judicial review.

The First Circuit considered § 1395ii before *Califano v. Sanders*. It avoided the question of federal question jurisdiction by finding jurisdiction under the A.P.A., which it held was not precluded by § 1395ii. *Adams Nursing Home of Williamstown, Inc. v. Mathews*, 1 Cir. 1977, 548 F.2d 1077.

Many district courts have considered the effect of § 1395ii. In *Mid Atlantic Nephrology Center, Ltd. v. Califano*, D. Md. 1977, 433 F.

This Court had taken an inconsistent position. In *Gallo v. Mathews*, 5 Cir. 1976, 534 F.2d 1137 (decided before *Califano v. Sanders* and relied upon by the district court here), the Court held that § 1395ii precluded review, but that § 10 of the A.P.A. provided it. In *Dr. John T. MacDonald Foundation, Inc. v. Califano*, 5 Cir. 1977,554 F.2d 714, the panel's second opinion followed *Califano v. Sanders* and held that no A.P.A. jurisdiction existed. The Court held that § 1395ii was not intended to preclude judicial review of issues, constitutional or statutory, which could be reviewed

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(Footnote 1 - continued)

Supp. 23, Judge Thomsen held that, in the absence of any other judicial review, §1395ii did not preclude federal question jurisdiction over a challenge to Departmental action. The court distinguished its case from most provider cases because the plaintiff was not making a claim for benefits, but instead was seeking injunctive relief "to compel HEW to abide by its own regulations". In *Humana of South Carolina, Inc. v. Mathews,* D.D.C. 1976, 419 F.Supp. 253, the court found jurisdiction by reading § 405(h) as applying only after an administrative hearing. In *St. Elizabeth Hospital v. Califano,* E.D.Ky. 1977, 441 F.Supp. 158, the court held that it had no federal question jurisdiction. In *Chelsea Community Hospital v. Michigan Blue Cross,* E.D.Mich. 1977, 436 F. Supp. 1050,the court held that review of statutory issues was precluded. The court was troubled by the thought that jurisdiction for constitutional issues might be completely foreclosed. It assumed that jurisdiction existed and found the constitutional claims without merit. In *Medical center of Independence v. Califano,* W.D. Mo. 1977, 433 F. Supp. 837, the court held that it had no federal question jurisdiction over pre-1973 claims. The court also held that §1395ii foreclosed mandamus jurisdiction under 28 U.S.C. §1361. In *Pacific Coast Medical Enterprises v. Califano,* C.D. Cal.1977, 440 F.Supp. 296, the court held that the statute prevented review of statutory issues, but not constitutional issues. It held, however, that the issues cast by the plaintiff in due process terms were in fact statutory issues. That court found mandamus was unavailable because the case was not proper for such relief under the general standards applied to mandamus petitions. A unique approach was taken by the district court in *Umedco, Inc. v. Califano,* C.D. Cal., June 9, 1977, Civ. No. 76-104 HP. That court distinguished *Salfi* as applying only to beneficiaries' claims. It held that it should not apply to providers' claims, and found jurisdiction to consider any constitutional issues.

in no other way.[2] We withheld deciding this case to await the result of this Court's reconsideration of *MacDonald* en banc. That decision, reported at 571 F.2d 328, resolves our major issue.

The Court en banc held that "§ 405(h), incorporated into § 1395ii of the Medicare Act, precludes all review of the Secretary's decisions by federal district courts brought under § 1331". 571 F.2d at 331. The Court refused to find a distinction between § 405(h) in the Title II context and §1395ii in the Medicare context because of the differing availability of review under § 405(g). Instead, it adopted the Supreme Court's position in *Weinberger v. Salfi*, 1975, 422 U.S. 749, 95 S.Ct. 2457, 45 L.Ed.2d 522, that neither statutory nor constitutional claims could be reviewed under the Act.

As a matter of statutory construction, the major difference between our case and *MacDonald*, as resolved by the en banc Court[3] , is that these plaintiffs complain not of a decision denying reimbursement but of a regulation which does not affect reimbursement. *Salfi*, relied upon by the Court en banc, shows that distinction to be unimportant. In *Salfi* widows brought a class action challenging on constitutional grounds the statute's failure to cover certain women. The Court gave a broad reading to the third sentence of §405(h)

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2. The panel reached this conclusion with some reluctance. "We [find jurisdiction] realizing that our construction is strained. . .." 554 F.2d at 718. Judge Clark dissented, holding that Congressional failure to incorporate more of §405(g) was not a mistake, but a conscious and permissible choice to limit review.

3. The *MacDonald* case could have been distinguished from this case because it dealt with a provider who could seek relief for periods after 1973 through the amendments to § 1395oo. The second panel opinion seems to read the amendments as Congressional correction of an oversight. 554 F.2d at 716. The Court en banc did not consider the amendments significant in construing the preclusion statute.

and held that it was "more than a codified requirement of administrative exhaustion". 422 U.S. at 757, 95 S.Ct. at 2468. It then distinguished *Johnson v. Robison*, 1974, 415 U.S. 361, 94 S.Ct. 1160, 39 L.Ed.2d 389. In that case a challenge was brought to a provision concerning veterans' benefits. The Court held that review of a statutory limitation was not precluded by a section providing that decisions of the Administrator

> "on any question or law or fact . . . shall be final and conclusive and no other official or any court of the United States shall have power or jurisdiction to review any such decision . . .."

38 U.S.C. §211(a), quoted in *Salfi*, 422 U.S. at 761; 95 S.Ct. at 2465. The Court had found jurisdiction in *Johnson*, in spite of this language. The *Salfi* Court explained that while the Veterans' Administration statute precluded only review of *decisions* of the Administrator, § 405(h) extended to any *action* to recover on any claim. Thus, the fact that no administrative hearing or decision was involved in the instant case does not serve as a relevant distinction from *MacDonald*. This Court has decided that the Medicare Act withdraws jurisdiction from the district courts over actions like this one.

This construction of §1395ii does not end our inquiry. We must determine whether this construction totally precludes judicial consideration of claims of CMS, statutory and constitutional. If it does, we must consider whether such preclusion itself violates the requirements of due process.

The question of Congressional power over jurisdiction is both ancient and difficult. It involves the most sensitive re-

lationships between coequal branches of the federal government. Courts and commentators have long discussed the issue.[4] While many commentators may have decided it, it is fair to say that the Supreme Court has not. Under *MacDonald*, this Court can only say:

> "Happily, we need resolve neither Congress' intent to preclude review of constitutional claims nor the constitutionality of a statute so construed. We would face these issues only if all avenues of review were precluded. In *Whitecliff*, however, the Court of Claims determined it to have jurisdiction to review claims arising under the Medicare Act."

571 F.2d at 332.

This particular suit cannot be brought in the Court of Claims. Its jurisdiction is founded on 28 U.S.C. § 1491,

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4. The Court has recently expressed doubts about the constitutionality of foreclosing all review of constitutional issues.

> "There is another reason why *Johnson v. Robison* is inapposite. It was expressly based, at least in part, on the fact that if § 211(a) reached constitutional challenges to statutory limitations, then absolutely no judicial consideration of the issue would be available. Not only would such a restriction have been extraordinary, such that 'clear and convincing' evidence would be required before we would ascribe such intent to Congress, [citations omitted] but it would have raised a serious constitutional question of the validity of the statute as so construed."

Weinberger v. Salfi, 422 U.S. at 762, 95 S.Ct. at 2465.

A thorough discussion of this whole area is found in P. Bator, P. Mishkin, D. Shapiro, and H. Wechsler, The Federal Courts and the Federal System, Note on the Power of Congress to Limit the Jurisdiction of Federal Courts, 313-375 (2d ed. 1973). *See also Caulfield v. U.S. Dept. of Agriculture*, 5 Cir. 1961, 293 F.2d 217 (en banc); K. Davis, Administrative Law in the Seventies, §2809 (1976); L. Jaffe, Judicial Control of Administrative Action, 376-94 (1965).

which was never part of the section 41 of title 28 mentioned in §405(h). It has jurisdiction over claims against the United States, without limitation as to jurisdictional amount.[5] That Court cannot provide the equitable or declaratory relief sought in this suit. *United States v. Alire*, 1868, 73 U.S. 573, 6 Wall. 573, 18 L.Ed. 947; *United States v. Jones*, 1886, 131 U.S. 1, 9 S.Ct. 669, 33 L.Ed. 90; *United States v. King*, 1969, 395 U.S. 1, 89 S.Ct. 1501, 23 L.Ed.2d 52. Nevertheless, the issue raised by the plaintiff could be heard by that Court if CMS can state a claim for damages or at least for nominal damages.[6] Only the relief granted would be different, and Congress has power over the relief granted suitors against the United States and its officers.[7]

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5. The Tucker Act also provides concurrent jurisdiction in the district courts for claims of less than $10,000. 28 U.S.C. § 1346(a). The district courts would not have such jurisdiction over this claim, however, because §1346(a) was part of section 41, and hence is within the language of §405(h).

6. For example, violation of due process rights, standing alone, has been held to found a claim for nominal damages. *Carey v. Piphus*, 1978, ---U.S.---, 98 S.Ct. 1042, 55 L.Ed 2d 252. This plaintiff also alleges that its members' time is being wasted in violation of their constitutional rights. Therefore, a successful action would also involve actual damages. We note the plaintiff alleged that more than $10,000 was in controversy.

7. Congress could refuse to waive sovereign immunity at all, and deny all litigants against the United States any remedies. It may also restrict parties seeking to litigate certain claims to specified courts, even if the claims are of constitutional magnitude. *See Yakus v. United States*, 1944, 321 U.S. 414, 64 S.Ct. 660, 88 L.Ed. 834, where the Court held that a constitutional challenge to wage and price controls could not be brought in the Emergency Court of Appeals. *Cf. Morris v. Gressette*, 1977, 432 U.S. 491, 97 S.Ct. 2411, 53 L.Ed.2d 506, which held that the decision of the Attorney under the Voting Rights Act was not subject to judicial review. The statute provided that review of changes in a state's electoral system was proper either through a declaratory judgment action in the District of Columbia, or through submission to the

The resolution we have reached is not pleasant. CMS has waited nearly three years for the resolution of its suit. The parties have briefed and argued their cases. When the suit was filed, before *Califano v. Sanders* and before *MacDonald*, the action gave no sign of being appropriate for the Court of Claims. Now, we must deny both parties a decision on the merits where at least one argument is substantial. But the alternative is to find that Congress cannot cut off our jurisdiction over these issues while providing another court, the Court of Claims, to hear the issues. That is a decision we cannot make. Moreover, we respect the ingenuity of lawyers. We do not exclude the possibility of plaintiff's counsel casting an action in terms of mandamus that might resolve what is obviously an important issue to the private hospitals in this country.

The decision of the district court is vacated, and this suit is remanded for dismissal without prejudice to the plaintiff to file other appropriate proceedings.

Vacated and remanded.

(Footnote 7 - continued)

Attorney General. Congress may also limit the availability of equitable relief in federal courts to private parties in suits against other private parties. The Norris-LaGuardia Act, restricting the use of federal injunctions in labor disputes, is a prime example. 29 U.S.C. §101-115. *See Lauf v. E.G. Shinner & Co.*, 1938, 303 U.S. 323, 58 S.Ct. 578, 82 L.Ed. 872. Remedies against the government have been limited in the context of Selective Service cases, although those cases do not easily lend themselves to a consistent interpretation. *See generally* Federal Courts and the Federal System at 365-72. The federal courts are also barred from issuing injunctions against the collection of federal taxes. Litigants are left to either refund suits or suits in the tax court. 26 U.S.C. §7421.

APPENDIX B

CONSTITUTIONAL PROVISIONS AND STATUTES

UNITED STATES CONSTITUTION, AMENDMENT 5:

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

28 U.S.C. §1331:

(a) the district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitution,laws, or treaties of the United States except that no such sum or value shall be required in any such action brought against the United States, any agency thereof, or any officer or employee thereof in his official capacity.

(b) Except when express provision therefor is otherwise made in a statute of the United States, where the plaintiff is finally adjudged to be entitled to recover less than the sum or value of $10,000, computed without regard to any setoff or counterclaim to which the defendant may be adjudged to be entitled, and exclusive of interests and costs, the district court may deny costs to the plaintiff and, in addition, may impose costs on the plaintiff.
As amended Oct. 21, 1976, Pub.L. 94-574, §2,90 Stat. 2721.

5 U.S.C. §551:

For the purpose of this subchapter---

(1) "agency" means each authority of the Government of the United States, whether or not it is within or subject to review by another agency, but does not include --

(A) the Congress;

(B) the courts of the United States;

(C) the governments of the territories or possessions of the United States;

(D) the government of the District of Columbia; except as to the requirements of section 552 of this title --

(E) agencies composed of representatives of the parties or of representatives of organizations of the parties to the disputes determined by them;

(F) courts martial and military commissions;

(G) military authority exercised in the field in time of war or in occupied territory; or

(H) functions conferred by sections 1738, 1739, 1743, and 1744 of title 12; chapter 2 of title 41; or sections 1622, 1884, 1881-1902, and former section 1641(b) (2), of title 50, appendix;

(2) "person" includes an individual, partnership, corporation, association, or public or private organization other than an agency;

(3) "party" includes a person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party, in an agency proceeding, and a person or agency admitted by an agency as a party for limited purposes;

(4) "rule" means the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency and includes the approval or prescription for the future of rates, wages, corporate or financial structures or reorganizations thereof, prices, facilities, appliances, services or allowances therefor or of valuations, costs, or accounting, or practices bearing on any of the foregoing;

(5) "rule making" means agency process for formulating, amending, or repealing a rule;

(6) "order" means the whole or a part of a final disposition, whether affirmative, negative, injunctive, or declaratory in form, of an agency in a matter other than rule making but including licensing;

(7) "adjudication" means agency process for the formulation of an order;

(8) "license" includes the whole or a part of an agency permit, certificate, approval, registration, charter, membership, statutory exemption or other form of permission;

(9) "licensing" includes agency process respecting the grant, renewal, denial, revocation, suspension, annulment, withdrawal, limitation, amendment, modification, or conditioning of a license;

(10) "sanction" includes the whole or a part of an agency--

(A) prohibition, requirement, limitation, or other condition affecting the freedom of a person;

(B) withholding of relief;

(C) imposition of penalty or fine;

(D) destruction, taking, seizure, or withholding of property;

(E) assessement of damages, reimbursement, restitution, compensation, costs, charges, or fees;

(F) requirement, revocation, or suspension of a license; or

(G) taking other compulsory or restrictive cation;

(11) "relief" includes the whole or a part of an agency--

(A) grant of money, assistance, license, authority, exemption, exception, privilege, or remedy;

(B) recognition of a claim, right, immunity, privilege, exemption, or exception; or

(C) taking of other action on the application or petition of, and beneficial to, a person;

(12) "agency proceeding" means an agency process as defined by paragraphs (5) (7), and (9) of this section;

(13) "agency action" includes the whole or a part of an agency rule, order, license, sanction, relief, or the equivalent or denial thereof, or failure to act; and

(14) "ex parte communication" means an oral or written communication not on the public record with respect to which reasonable prior notice to all parties is not given, but it shall not include requests for status reports on any matter or proceeding covered by this subchapter.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 381; Pub.L. 94-409 § 4(b), Sept. 13, 1976, 90 Stat. 1247.

5 U.S.C. § 553:

(a) This section applies, according to the provisions thereof, except to the extent that there is involved --

(1) a military or foreign affairs function of the United States; or

(2) a matter relating to agency management or personnel or to public property, loans, grants, benefits, or contracts.

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include--

(1) a statement of the time, place, and nature of public rule making proceedings;

(2) reference to the legal authority under which the rule is proposed; and

(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply -

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or

(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons thereof in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

(c) After notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation. After consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. When rules are required by statute to be made on the record after opportunity for an agency hearing, sections 556 and 557 of this title apply instead of this subsection.

(d) The required publication or service of a substantive rule shall be made not less than 30 days before its effective date, except--

(1) a substantive rule which grants or recognizes an exemption or relieves a restriction;

(2) interpretative rules and statements of policy; or

(3) as otherwise provided by the agency for good cause found and published with the rule.

(e) Each agency shall give an interested person the right to

petition for the issuance, amendment, or repeal of a rule. Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 383.

5 U.S.C. §701:

(a) This chapter applies, according to the provisions thereof, except to the extent that –

(1) statutes preclude judicial review; or

(2) agency action is committed to agency discretion by law.

(b) For the purpose of this chapter –

(1) "agency" means each authority of the Government of the United States, whether or not it is within or subject to review by another agency, but does not include –

(A) the Congress;

(B) the courts of the United States;

(C) the governments of the territories or possessions of the United States;

(D) the government of the District of Columbia;

(E) agencies composed of representatives of the parties or of representatives of organizations of the parties to the disputes determined by them;

(F) courts martial and miliary commissions;

(G) military authority exercised in the field in time of war or in occupied territory; or

(H) functions conferred by sections 1738, 1739, 1743, and 1744 of title 12; chapter 2 of title 41; or sections 1622, 1884, 1891-1902, and former section 1641(b) (2), of title 50, appendix; and

(2) "person", "rule", "order", "license", "sanction", "relief", and "agency action" have the meanings given them by section 551 of this title.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 392.

5 U.S.C. §702:

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States: *Provided*, That any mandatory or injunctive decree shall specify the Federal officer or officers (by name or by title), and their successors in office, personally responsible for compliance. Nothing herein (1) affects other limitations on judicial review or the power or duty of the court to dismiss any action or deny relief on any other appropriate legal or equitable ground; or (2) confers authority to grant relief if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 392; Pub.L. 94-574, § 1, Oct. 21, 1976, 90 Stat. 2721.

5 U.S.C. § 703:

The form of proceeding for judicial review is the special statutory review proceeding relevant to the subject matter in a court specified by statute or, in the absence or inadequacy thereof, any applicable form of legal action, including actions for declaratory judgments or writ of prohibitory or mandatory injunction or habeas corpus, in a court of competent jurisdiction. If no special statutory review proceeding is applicable, the action for judicial review may be brought against the United States, the agency by its official title, or the appropriate officer. Except to the extent that prior, adequate, and exclusive opportunity for judicial review is provided by law, agency action is subject to judicial review in civil or criminal proceedings for judicial enforcement.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat 392; Pub. L. 94-574, § 1, Oct. 21, 1976, 90 Stat. 2721.

5 U.S.C. § 704:

Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review. A preliminary, procedural, or intermediate agency action or ruling not directly reviewable is subject to review on the review of the final agency action. Except as otherwise expressly required by statute, agency action otherwise final is final for the purposes of this section whether or not there has been presented or determined an application for a declaratory order, for any form of reconsideration, or, unless the agency otherwise requires by rule and provides that the action meanwhile is inoperative, for an appeal to superior agency authority.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat . 392.

5 U.S.C. § 705:

When an agency finds that justice so requires, it may postpone the effective date of action taken by it, pending judicial review. On such conditions as may be required and to the extent necessary to prevent irreparable injury, the reviewing court, including the court to which a case may be taken on appeal from or on application for certiorari or other writ to a reviewing court, may issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 393.

5 U.S.C. § 706:

To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall --

(1) compel agency action unlawfully withheld or unreasonably delayed; and

(2) hold unlawful and set aside agency action, findings, and conclusions found to be --

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

(B) contrary to constitutional right, power, privilege, or immunity;

(C) in excess of statutory jurisdiction, authority, or

limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

Pub.L. 89-554, Sept. 6, 1966, 80 Stat. 393.

42 U.S.C. §405 (g,h):

(g) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides or has his principal place of business, or, if he does not reside or have his principal place of business within any such judicial district, in the United States District Court for the District of Columbia. As part of his answer the Secretary shall file a certified copy of the transcript of the record including the evidence upon which the findings and decision complained of

are based. The court shall have power to enter, upon the pleadings and transcript of the record, a judgment affirming, modifying, or reversing the decision of the Secretary, with or without remanding the cause for a rehearing. The findings of the Secretary as to any fact, if supported by substantial evidence, shall be conclusive, and where a claim has been denied by the Secretary or a decision is rendered under subsection (b) of this section which is adverse to an individual who was a party to the hearing before the Secretary, because of failure of the claimant or such individual to submit proof in conformity with any regulation prescribed under subsection (a) of this section, the court shall review only the question of conformity with such regulations and the validity of such regulations. The court shall, on motion of the Secretary made before he files his answer, remand the case to the Secretary for further action by the Secretary, and may, at any time, on good cause shown, order additional evidence to be taken before the Secretary, and the Secretary shall, after the case is remanded, and after hearing such additional evidence if so ordered, modify or affirm his findings of fact or its decision, or both, and shall file with the court any such additional and modified findings of fact and decision, and a transcript of the additional record and testimony upon which his action in modifying or affirming was based. Such additional or modified findings of fact and decision shall be reviewable only to the extent provided for review of the original findings of fact and decision. The judgment of the court shall be final except that it shall be subject to review in the same manner as a judgment in other civil actions. Any action instituted in accordance with this subsection shall survive notwithstanding any change in the person occupying the office of Secretary or any vacancy in such office.

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or govern-

mental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 1395 ff:

(a) The determination of whether an individual is entitled to benefits under part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) (1) Any individual dissatisfied with any determination under subsection (a) of this section as to --

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason

of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

Aug. 14, 1935, c. 531, Title XVIII, § 1869, as added July 30, 1965, Pub.L. 89-97, Title I, § 102(a), 79 Stat. 330, and amended Oct. 30, 1972, Pub.L. 92-603, Title II, § 2990(a), 86 Stat. 1464.

42 U.S.C. § 1395ii:

The provisions of sections 406 and 416(j) of this title, and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 405 of this title, shall also apply with respect to this subchapter to the same extent as they are applicable with respect to subchapter II of this chapter.

Aug. 14, 1935, c. 531, Title XVIII, § 1872, as added July 30, 1965, Pub.L. 89-97, Title I, § 102(a), 79 Stat. 332, and amended Oct. 30, 1972, Pub.L. 92-603, Title II, § 242(a), 86 Stat. 1419.

42 U.S.C. § 1395 oo:

(a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider

Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section, if--

(1) such provider --

(A) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply.

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1) (A) or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

(b) The provisions of subsection (a) of this section shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal

(but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more.

(c) At such hearing, the provider of services shall have the right to be represented by counsel, to introduce evidence, and to examine and cross-examine witnesses. Evidence may be received at any such hearing even though inadmissible under rule of evidence applicable to court procedure.

(d) A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

(e) The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section. In the course of any hearing the Board may administer oaths and affirmations. The provisions of subsections (d), (e), and (f) of section 405 of this title with respect to subpenas shall apply to the Board to the same extent as they apply to the Secretary with respect to subchapter II of this chapter.

(f) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses or modifies (adversely to such provider) the Board's decision. In any case where such a reversal or modification occurs the provider of services may obtain a review of such decision by a civil action commenced within 60 days of the date he is notified of the Secretary's reversal or modification. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title.

(g) The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

(h) The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of cost reimbursement, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter

terms to the extent necessary to permit staggered terms of office.

(i) The Board is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Board such secretarial, clerical, and other assistance as the Board may require to carry out its functions.

Aug. 14, 1935, c. 531, title XVIII, §1878, as added Oct. 30, 1972, Pub.L. 92-603, Title II, § 243(a), 86 Stat. 1420.

42 U.S.C. § 1395 x(k):

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this subchapter and if it provides--

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary determines tht the utilization review procedures established pursuant to subchapter XIX of this chapter are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this subchapter that the procedures established pursuant to subchapter XIX of this chapter be utilized instead of the procedures required by this section.